No. 16-1140

In The Supreme Court of the United States

NATIONAL INSTITUTE OF FAMILY AND LIFE ADVOCATES, d/b/a NIFLA, *et al.*,

Petitioners,

v.

XAVIER BECERRA, ATTORNEY GENERAL, *et al.*,

Respondents.

On Writ Of Certiorari To The United States Court Of Appeals For The Ninth Circuit

BRIEF OF AMICUS CURIAE COMPASSION & CHOICES IN SUPPORT OF RESPONDENTS

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INTEREST OF AMICUS CURIAE COMPASSION & CHOICES[1]

Compassion & Choices, with more than 450,000 supporters, is the nation's oldest, largest, and most active nonprofit organization committed to improving care and expanding choice at the end of life. For over thirty years, Compassion & Choices has envisioned a society where people receive state-of-the-art healthcare and a full range of choices for dying in comfort, dignity, and control. Compassion & Choices aims to ensure that individuals understand the benefits and burdens of all feasible treatment options, that treatment decisions are fully respected, and that healthcare reflects a person's values and priorities for life's final chapter.

Compassion & Choices offers free consultation, planning resources, referrals, assistance with advance directives, and support throughout the country through its End of Life Consultation Program. Advocating at the state and federal levels, Compassion & Choices pursues policies that empower individuals in relation to their healthcare decisions and, if necessary, litigates or participates as amicus to achieve better medical care and access to a full range of end-of-life options.

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[1] No counsel for a party authored this brief in whole or in part, and no such counsel or party made a monetary contribution to fund the preparation or submission of this brief. No person or entity, other than amicus curiae and its counsel made a monetary contribution to the preparation or submission of this brief. Petitioners have filed a blanket consent to the filing of amicus briefs, and Respondents have consented to the filing of this brief.

Compassion & Choices believes that the First Amendment does not prohibit the states from enacting reasonable laws requiring providers of healthcare-related services, including physicians, long-term care facilities and hospices, to disclose neutral and truthful information to individuals regarding lawful healthcare alternatives. Compassion & Choices is concerned that a ruling for the petitioners could threaten the validity of such laws disclosing options at the end of life, and substantially impair patient decision-making.

SUMMARY OF ARGUMENT

Recognizing that historical "informed consent" practices and rules still left many people ill-informed regarding their end-of-life healthcare choices, both numerous states and the federal government have enacted regulations requiring disclosures regarding end-of-life treatment options, such as the right to execute advance directives, the right to refuse treatment, or information concerning options such as palliative care or, in those states that permit it, medical-aid-in-dying. Those disclosure requirements enhance the relationship of trust and confidence between patients and their healthcare providers by ensuring they can have frank, honest discussions about some of the most momentous decisions of patients' lives.

While the disclosure laws at issue in this case relate to access to reproductive healthcare, this Court's analysis of those laws' constitutionality has profound

implications for the enforceability of end-of-life disclosure rules as well. The Court should reject petitioners' invitation to use the First Amendment to narrowly cabin "informed consent" rules and enable those providing healthcare-related services to avoid disclosing the availability of treatment options they do not provide or morally oppose. Instead, the Court should hold that the First Amendment permits reasonable regulations requiring healthcare providers to provide neutral, truthful information to patients or prospective patients regarding their lawful treatment choices.

ARGUMENT

I. STATE AND FEDERAL LAW SUPPLEMENTS THE DOCTRINE OF INFORMED CONSENT BY REQUIRING HEALTHCARE PROVIDERS TO MAKE NEUTRAL AND TRUTHFUL DISCLOSURES TO PATIENTS REGARDING LAWFUL END-OF-LIFE DECISIONS.

A. The Doctrine of Informed Consent Requires Certain Disclosures Concerning an Individual's End-Of-Life Options.

Historically, physicians were obliged to disclose only that information necessary to persuade patients to do what the physician thought was best, or to try to offer hope and comfort. Sonia M. Suter, *The Politics Of Information: Informed Consent In Abortion And End-Of-Life Decision Making*, 39 Am. J.L. & Med. 7, 12

(2013). Over time, however, the focus shifted to patient consent, and whether the physician disclosed enough information for the patient's treatment decision to be a "true exercise of self-determination." *Id.* Today, the doctrine of "informed consent," which includes the right to refuse treatment, "has become firmly entrenched in American tort law." *Cruzan v. Dir., Missouri Dep't of Health*, 497 U.S. 261, 269, 110 S.Ct. 2841, 111 L.Ed.2d 224 (1990).

The scope of what constitutes informed consent varies by State, but is generally defined either by what a reasonable patient would want to know or by what the standard of care requires a reasonable physician to disclose. Suter, *supra*, at 14-15; Nadia N. Sawicki, *Mandating Disclosure of Conscience-Based Limitations on Medical Practice*, 42 Am. J.L. & Med. 85, 111 (2016). Regardless, the doctrine is limited by its tort roots. It typically applies only to physicians (or other medical professionals), requires only disclosure of medical information, and arises only in the context of a specific procedure or treatment. Sawicki, *supra*, at 111-12.

In addition, physicians may have religious or moral objections to certain forms of lawful medical treatment, including end-of-life options. Sawicki, *supra*, at 87. Even where professional ethics would dictate disclosure, statistics suggest that a large percentage of physicians and healthcare institutions do not believe they have an obligation to provide patients with information regarding treatment options to which they object on religious or moral grounds. *Id.* at 92-95, 100-01;

Suter, *supra*, at 42, 51. In short, many individuals are unaware of the end-of-life options they may have.[2]

B. States And Federal Laws Require Healthcare Providers to Disclose Additional Information to Patients Regarding Various End-Of-Life Options.

The doctrine of informed consent thus results in only *some* individuals receiving *some* information they may want to know as they approach life's final stages. Given the deeply significant personal and societal interests implicated by these decisions, which exceed almost any other kind of medical decisions, *see* Suter, *supra*, at 18-19, many States have enacted laws that require healthcare providers to disclose truthful information regarding lawful end-of-life options.

It is important to note that many of these laws entail disclosures that exceed a traditionally recognized duty of informed consent in several ways. For instance, rather than apply only to physicians or specialized medical professionals, many of these laws also apply to other healthcare providers that commonly provide care and services to the elderly, infirm or terminally ill, including hospitals, hospices, long-term care facilities (such as nursing homes and assisted living facilities), and home healthcare agencies.

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[2] As the Michigan legislature found, "patients with reduced life expectancy due to advanced illnesses . . . are often unaware of their legal rights, particularly with regard to controlling end-of-life decisions." Mich. Comp. Laws § 333.5652(1)(c) (2018).

Likewise, rather than require disclosure only in advance of or in connection with a particular medical procedure, prescribed drug, or course of treatment, many of these laws also require healthcare providers to disclose information regarding end-of-life options at different times and upon different events, such as at the time of admission to a hospital or long-term care facility, in connection with the preparation of a care plan, upon a particular diagnosis or condition, or in response to a patient request. *See, generally*, Suter, *supra*, at 29-33.

These laws typically fall into at least one of three categories. To start, many States require providers – particularly hospices, long-term care facilities, and home healthcare agencies – to inform patients or residents of their right to execute advance directives that specify what kinds of treatments, procedures or medicines should be administered if they are no longer able to make healthcare decisions for themselves, such as do-not-resuscitate orders.[3] Federal law likewise requires that facilities receiving Medicare or Medicaid funds inform residents of their rights regarding advance

[3] *See, e.g.*, Ala. Admin. Code § r. 420-5-10-.05(3)(h) (2018); Ark. Admin. Code § 007.05.4-11(F) (2018); Ark. Admin. Code § 007.05.11-10(F) (2018); Ark. Admin. Code § 016.06.35-136.000 (2018); Cal. Health & Safety Code § 1569.156(a)(3) (2018); 6 Colo. Code Regs. § 1011-1:XXVI-6.4(d)(2) (2018); Fla. Stat. § 765.110(1) (2018); Idaho Admin. Code § 16.03.09.235.01(a)(2) (2018); N.J. Stat. § 26:2H-65(a)(2) (2018); N.M. Admin. Code § 7.27.6.6-6.8 (2018); Okla. Admin. Code § 310:661-5-4.1(b)(2) (2018); Okla. Admin. Code § 317:30-3-13(a)(2) (2018); Or. Rev. Stat. § 127.649(1)(a)(A) (2018); Vt. Admin. Code § 12-4-200:3.8 (2018); Wash. Admin. Code § 388-97-0280(3)(c)(ii) (2018).

directives. *See* 42 U.S.C. § 1395cc(f)(1) (2000); 42 C.F.R. § 489.102(a)(1)(ii) (2018); 42 C.F.R. § 418.52(a)(2) (2018).

Next, some States require healthcare providers – as part of a duty of informed consent to individuals with a terminal or advanced illness, in the context of advance directives or on a stand-alone basis – to specifically inform patients or residents regarding lawful and medically appropriate alternative forms of end-of-life treatment, palliative care, and one's right to refuse potentially life-saving or life-prolonging treatment.[4]

Finally, in the handful of jurisdictions permitting individuals with terminal conditions to receive medical-aid-in-dying, often called "death with dignity" laws, upon the voluntary (and typically written) request of the patient for a prescription for medication that will provide comfort at the end of life and verification of the terminal prognosis, the States require physicians who write a prescription to fully inform the patient of the risks and probable fatal results if and when the patient

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[4] *See, e.g.*, Ala. Admin. Code § r. 420-5-10-.05(3)(h) (2018); Ark. Admin. Code § 007.05.11-10(F)(2)(b) (2018); Ark. Admin. Code § 007.05.4-11(F)(2)(b) (2018); Ark. Admin. Code § 016.06.35-136.000 (2018); Cal. Health & Safety Code § 1569.156(a)(3) (2018); Colo. Rev. Stat. § 25.5-4-413(1) (2018); Mich. Comp. Laws § 333.5655(b) (2018); N.Y. Pub. Health § 2997-c(2)(a) (2018); N.Y. Pub. Health § 2997-d(2) (2018); Or. Rev. Stat. § 127.649(1)(a)(A) (2018); Vt. Stat. Ann. tit. 18 § 1871(b) (2018); Wash. Admin. Code § 388-97-0260(3)(b) (2018).

self-administers the medication, as well as other available treatments and care options.[5]

The disclosure laws outlined above are justified not only by patients' interest in knowing the full array of their healthcare options at the end of life, but by our society's interest in fostering a relationship of trust and confidence between patients and their healthcare providers. *Cf.*, *e.g.*, *Washington v. Glucksberg*, 521 U.S. 702, 731, 117 S.Ct. 2258, 138 L.Ed.2d 772 (1997) (discussing the state interest in "the trust that is essential to the doctor-patient relationship"); *Canterbury v. Spence*, 464 F.2d 772, 782 (D.C. Cir. 1972) (A physician's "duty [is] to impart information which the patient has every right to expect. The patient's reliance upon the physician is a trust of the kind which traditionally has exacted obligations beyond those associated with armslength transactions. His dependence upon the physician for information affecting his well-being, in terms of contemplated treatment, is well-nigh abject.") (footnotes omitted). These disclosure laws give patients the confidence that their healthcare providers are being fully candid with them about their treatment options – including options that the provider may not offer, or with which the provider may disagree.[6] Those

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[5] *See*, *e.g.*, Cal. Health & Safety Code § 443.5(a)(2) (West 2018); Or. Rev. Stat. § 127.815(1)(c) (2018); Vt. Stat. Ann. tit. 18 § 5283(a)(6) (2018); Wash. Rev. Code § 70.245.040(1)(c) (2018).

[6] Depending on their personal beliefs, physicians and other healthcare providers may be opposed not only to medical-aid-in-dying, but to any number of treatment options, including other end-of-life treatment options such as declining life-saving or

disclosures enable patients to have open and honest discussions with their healthcare providers about their treatment options – discussions in which the healthcare provider is free to make his or her personal opinions and recommendations known.

II. THE FIRST AMENDMENT PERMITS STATES TO REQUIRE HEALTHCARE PROVIDERS TO MAKE NEUTRAL AND TRUTHFUL DISCLOSURES RELATED TO LAWFUL TREATMENT OPTIONS.

A. Petitioners' Arguments Could Be – and Indeed Have Been – Used to Attack End-Of-Life Disclosure Requirements.

In this case, petitioners advocate for an interpretation of the First Amendment that would, by extension, call into question many of the end-of-life disclosure laws discussed above. Petitioners contend that *all* content-based regulation of speech (other than the unprotected categories of speech the Court has previously recognized) is subject to strict scrutiny. (Pet. Br. 28-31.) Petitioners also urge this Court to reject any category of "professional speech" that would be subject to any lesser standard. (*Id.* 42-46.) Petitioners acknowledge that "informed consent" rules are generally permissible, but they argue for an extraordinarily narrow view of "informed consent" that would limit it only to information a licensed physician is required to

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life-prolonging treatment, or even common treatment options such as vaccinations, antibiotics, or blood transfusions.

provide before performing a specific medical procedure. (*Id.* 46-49.) Petitioners suggest that, because they do not *themselves* provide abortions, they cannot be required to inform their clients of the potential availability of public funding for that and other family planning and/or prenatal services under the rubric of "informed consent." (*See id.* 47-49.)

Like the disclosure laws at issue in this case, the end-of-life disclosure laws discussed in this brief are content-based, in that they require specific information to be provided to patients or facility residents in certain circumstances. And, as discussed, many of those laws require those disclosures beyond the traditional confines of "informed consent" rules. Under plaintiffs' theory, if a particular healthcare provider objects to and refuses to provide services relating to a particular lawful end-of-life option, that healthcare provider could also refuse to provide information regarding that option unless the disclosure law satisfied strict scrutiny. Such a rule would threaten to upend the extensive body of state and federal regulation of end-of-life disclosures that has been enacted around the nation, leaving suffering patients ill-informed about their lawful treatment options and harming the special relationship of trust and confidence between patients and their healthcare providers.

Petitioners go further in their advocacy, arguing for an even more extreme position that would essentially render end-of-life disclosure laws (or, really, *any* type of disclosure laws) unenforceable. Petitioners contend that, despite its facial neutrality in requiring only

truthful, factual information regarding treatment options, the mere *mention* of abortion means that the notice required of licensed clinics promotes a "viewpoint" favoring abortion that is contrary to petitioners' "viewpoint" opposing abortion. (Pet. Br. 37-39.) Petitioners ask this Court to hold such "viewpoint discrimination" against private speech to be *per se* unconstitutional. (*Id.* 57-60.)

If, as petitioners contend, any mention of a lawful treatment option amounts to promotion of a "viewpoint" favoring that treatment option, then any healthcare provider who objects to, for example, do-not-resuscitate orders or the refusal of life-prolonging treatment could simply refuse to comply with many of the end-of-life disclosure laws outlined above, claiming that they amounted to "viewpoint discrimination." Such a result would leave patients or facility residents' ability to make informed choices at the mercy of their healthcare providers' personal, private beliefs – an intolerable outcome.

The threat to end-of-life disclosure laws posed by the positions petitioners advance is not hypothetical. In *Vermont Alliance for Ethical Healthcare, Inc. v. Hoser*, 274 F. Supp. 3d 227 (D. Vt. 2017), for example, certain physicians and other healthcare providers sought to enjoin the enforcement of Vermont informed consent statutes to the extent that those statutes could be interpreted to require them to inform patients of their options under Vermont's medical-aid-in-dying statute. Like petitioners here, those healthcare providers claimed that such a requirement would violate

their First Amendment rights, and would amount to a requirement that they "counsel for" medical-aid-in-dying. *See id.* While the district court dismissed that case for lack of standing, *see id.*, the battle lines over end-of-life disclosure laws have plainly been drawn.

B. The First Amendment Permits Reasonable Regulations Requiring that Healthcare Providers Disclose Neutral, Truthful Information Concerning Lawful Treatment Options to Their Patients and Prospective Patients.

The Court should decline to go down the path petitioners advocate, and instead recognize that the First Amendment does not prohibit reasonable laws requiring healthcare providers to disclose truthful information regarding lawful treatment options – even if the healthcare provider does not offer, and in fact morally opposes, a particular treatment option that is subject to disclosure.

First, whether under the category of "professional speech" or under a broader understanding of "informed consent," the Court should recognize that the special relationship of trust and confidence between a healthcare provider and a patient or prospective patient justifies requirements that the provider inform the patient or prospective patient of his or her lawful healthcare options – regardless of whether that provider itself offers them or morally objects to them. *Cf. Canterbury*, 464 F.2d at 782 (a patient's "dependence upon

the physician for information affecting his well-being, in terms of contemplated treatment, is well-nigh abject").

That result is consistent with this Court's precedent. In *Planned Parenthood of Southeastern Pa. v. Casey*, 505 U.S. 833, 881-85, 112 S.Ct. 2791, 120 L.Ed.2d 674 (1992), for example, the Court upheld requirements that physicians provide information to women seeking abortions concerning the "probable gestational age of the child" and the availability of further information describing the fetus, medical assistance for childbirth, child support options, and adoption agencies and other abortion alternatives – even though that information had nothing to do with the medical risks or benefits of the medical procedure to be performed and, in many instances, related to services that the physicians did not themselves provide. *See id.* at 882 (acknowledging that certain of the required disclosures "have no direct relation to [the patient's] health").

Second, the Court should hold that reasonably providing neutral, truthful information regarding a treatment option does not amount to advocating for a "viewpoint" favoring that treatment option. *Cf. Hill v. Colorado*, 530 U.S. 703, 724-25, 120 S.Ct. 2480, 147 L.Ed.2d 597 (2000) (statute regulating speech-related conduct near healthcare facilities without reference to content of speech is not "viewpoint based"); *Employment Div., Dep't of Human Resources of Oregon v. Smith*, 494 U.S. 872, 878-79, 110 S.Ct. 1595, 108 L.Ed.2d 876 (1990) (if a "valid and neutral law of general applicability" has the "incidental effect" of burdening the free exercise of

religion or freedom of the press, "the First Amendment has not been offended.") (citation omitted).

Again, *Casey* is instructive. In that case, physicians were required to provide prospective abortion patients with "truthful, nonmisleading information about the nature of the procedure, the attendant health risks and those of childbirth, and the 'probable gestational age' of the fetus[.]" 505 U.S. at 882. The opinion of Justices O'Connor, Kennedy, and Souter concluded that requiring such information "may be permissible" as part of obtaining a woman's informed consent, even if it may have the incidental effect of reducing the number of abortions performed. *Id.* And the Court found no constitutional infirmity in requiring physicians to inform prospective patients of the availability of materials published by the state, even though those materials "expresse[d] a preference for childbirth over abortion." *See id.* at 882-83. If the disclosure regulations at issue in *Casey* did not amount to unconstitutional "viewpoint discrimination," then the licensed clinic disclosure regulation at issue in this case – which merely requires clinics to inform a prospective patient of the potential availability of lawful medical services (including both abortion *and* prenatal care) from an alternative provider, without advocating for or against those services – certainly cannot either.

Healthcare choices are among the most consequential, emotional decisions that a person makes in his or her life – including at the end of life. At those vulnerable junctures in life when healthcare choices must be made, patients and prospective patients rely

on their healthcare providers to provide them with complete, truthful information regarding their options. Allowing healthcare providers to violate that trust on the sole basis of their personal aversion to a particular treatment option leaves those patients ill-served and erodes the basis of the special relationship between healthcare providers and their patients. The First Amendment is not offended by requiring neutral, truthful disclosures in the context of that relationship.

CONCLUSION

Compassion & Choices respectfully asks the Court to affirm the decision of the Ninth Circuit, and to hold that the First Amendment does not forbid reasonable regulations requiring healthcare providers to provide neutral, truthful information to patients or prospective patients regarding the full range of their lawful treatment options.

Respectfully submitted,

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